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Issue date: 04Apr2001

CASE NO.: 1998-BLA-00823
1998-BLA-00824

In the Matter of:

SYLVIA J. TARR
WIDOW OF EDWARD G. TARR
Claimant

v.

CLINCHFIELD COAL CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER - DENYING BENEFITS UPON REMAND
FROM THE BENEFITS REVIEW BOARD

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901 et seq (the Act). The Act provides benefits to persons totally disabled due to pneumoconiosis and to certain survivors of persons who had pneumoconiosis and were totally disabled at the time of their death or whose death was caused by pneumoconiosis. Pneumoconiosis is a chronic dust disease of the lungs, including respiratory and pulmonary impairments arising out of coal mine employment, and is commonly referred to as black lung.[1]

Background

[1]The following reference will be used herein:"DX" for Director's exhibits.

Sylvia J. Tarr, Claimant, is the widow of Edward G. Tarr. They were married on August 7, 1953, and were living together at the time of his death on June 27, 1997. (DX 8). The death certificate was signed by Dr. Emory H. Robinette, the Miner's treating physician, who listed the cause of death as acute respiratory failure due to pulmonary fibrosis with coal workers' pneumoconiosis. (DX 70, 89). Another significant condition was gastrointestinal bleeding/gastritis. The Miner filed his original claim for benefits on March 4, 1996. (DX 1). After the Miner's death, his widow, Sylvia J. Tarr, filed her claim for survivor's benefits in a timely fashion on July 25, 1997. The instant claims involve both the Miner's claim of April 2, 1996, and the survivor's claim of July 25, 1997.

Pursuant to the Miner's original claim for benefits, the DOL initially awarded the Miner benefits, and on January 22, 1997, referred the matter to the Honorable Michael Lesniak, Administrative Law Judge, for a hearing. Unfortunately, the Miner expired before his scheduled hearing, and thus, prior to adjudication of his claim. Nonetheless, the Miner's claim went forward, and medical evidence was submitted in support of his claim. Under the constraints of the twenty day rule of 20 C.F.R § 725.456(b), the Employer, Clinchfield Coal Company, requested additional time to respond to the Miner's medical evidence. Accordingly, Judge Lesniak canceled the scheduled hearing and remanded the matter to the district director on August 6, 1997. The District Director interpreted the Employer's requested time extension and Judge Lesniak's subsequent remand as a Request for Modification, and issued a decision denying modification.

The DOL initially awarded survivor's benefits to the Claimant, but then revoked such award. Upon the Claimant's request, on May 6, 1998, the Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a formal hearing. A hearing was held before Judge Lawrence P. Donnelly in Abingdon, Virginia, on February 10, 1999, at which time all parties were given a full opportunity to present evidence and argument as provided in the Act and the Regulations issued thereunder, found at Title 20, Code of Federal Regulations. By the Decision and Order of June 14, 1999, Judge Donnelly awarded benefits in both claims. The Employer timely appealed to the Benefits Review Board ("Board").

In its Decision and Order of September 15, 2000, the Board affirmed Judge Donnelly's findings with respect to length of coal mine employment at 38.88 years and the designation of the Employer as the responsible operator. BRB, slip op. at 2. The Board further affirmed Judge Donnelly's consideration of Dr. Sargent's x-ray interpretation of 3/2 as a positive reading pursuant to § 718.202(a)(1), while considering Dr. Sargent's additional comments pursuant to § 718.203(b). BRB slip op. at 4, *citing Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999) (en banc). The Board held that Dr. Sargent's opinion regarding the source of the Miner's pneumoconiosis does not undermine the positive reading, and Judge Donnelly's treatment thereof was proper. BRB slip op. at 4.

The Board vacated Judge Donnelly's findings at § 718.202(a)(1), and remanded the matter with specific directions for the administrative law judge to consider as negative those readings recorded on standardized forms that indicate either no parenchymal abnormalities, no pleural abnormalities, or a negative interpretation. BRB slip op. at 3,

citing McMath v. Director, OWCP, 12 BLR 1-6 (1988). In its order, the Board also specifically directed the administrative law judge to reconsider the biopsy and autopsy evidence pursuant to § 718.202(a)(2), and provide a full discussion and rationale for his findings. BRB slip op. at 4, *citing* 20 C.F.R § 718.202(a)(2). The Board next directed the administrative law judge to reconsider all of the evidence at §§ 718.202(a)(1)-(4) together to determine whether the Claimant has established the existence of pneumoconiosis pursuant to *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000). BRB slip op. at 4, *citing* 20 C.F.R § 718.202(a)(1)-(4). Finally, the Board directed the administrative law judge to discuss separately his findings on total disability causation pursuant to § 718.204(b), and the Miner's cause of death pursuant to § 718.205. 20 C.F.R §§ 718.204(b), 718.205.

As Judge Donnelly had departed, Associate Chief Judge Thomas M. Burke reassigned this remand to me on December 13, 2000, together with an Order establishing a 30 day deadline for the submission of briefs on the remanded issues. The Employer submitted its brief on or about January 8, 2001. The Claimant did not favor me with a brief on the remanded issues.

Then, on February 9, 2001, the Honorable Emmet G. Sullivan of the United States District Court for the District Court of Columbia issued the Preliminary Injunction Order enjoining the implementation of certain amended regulations effective January 19, 2001 including, but not limited to, 20 C.F.R. §§ 718.104(d), 718.201(a)(2), 718.201(c), 718.204(a), 718.205(c)(5), 718.205(d). Pursuant to ¶3 of this order, on February 21, 2001, I issued to the parties an Order for Briefing by which parties had to submit briefs stating how the aforementioned regulations will, if at all, affect the outcome of this claim. Both the Director and the Employer submitted briefs pursuant to the February 21, 2001, Order, stating that the new regulations will not affect the outcome of the claim.[2] According to the terms of the February 21, 2001, Order for Briefing, I will construe the Claimant's silence on the issue as acquiescence to the Director and Employer's position. Thus, this claim shall not be stayed under the Preliminary Injunction Order of February 9, 2001. My independent review of the record shows that the new regulations as cited in my Order of February 21, 2001, will have no effect on the outcome of this matter.

Issues

(1) Whether the Miner had pneumoconiosis; and
(2) Whether pneumoconiosis caused or contributed to the Miner's disability, or caused, contributed to, or hastened the Miner's death.

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[2]The Director and Employer assert that controlling precedent of the United States Court of Appeals for the Fourth Circuit is such that the new regulations do not materially change the standards for adjudication of the issues in this case. Moreover, as all medical evidence in this case was developed before January 19, 2001, the new regulations are inapplicable.

Entitlement to Benefits: In General

To receive black lung benefits as a qualifying surviving spouse of a miner, the Claimant must prove (1) that the miner suffered from pneumoconiosis; (2) that the miner's pneumoconiosis arose, at least in part, out of coal mine employment; and (3) that pneumoconiosis caused or substantially contributed to the miner's death. Failure to prove any of these requisite elements precludes a finding of entitlement. 20 C.F.R. §§ 718.201, 718.203, 718.205(c). *See United States Steel Mining Company, Inc., v. Director, OWCP*, 187 F.3d 384 (4th Cir. 1999). The Claimant has the burden of persuasion by a preponderance of the evidence to establish each of these elements. See 30 U.S.C. § 932(a); *Piney Mountain Coal Co. v. Mays*, 176 F.3d 753 (4th Cir. 1999).

Determination of Pneumoconiosis

Claimant must first establish the presence of pneumoconiosis. Pursuant to § 718.202, a deceased miner can demonstrate pneumoconiosis by means of: (1) x-rays interpreted as being positive for the disease; or (2) biopsy or autopsy evidence; or (3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or (4) a reasoned medical opinion which concludes presence of the disease, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical exams, and medical and work histories. 20 C.F.R. § 718.202.

A. Chest X-ray Evidence

The Employer argues that the x-ray evidence does not establish pneumoconiosis. (Emp. Brief, 1/8/01, at 2-3). There are seven x-ray films of record, two developed in 1974, two developed in 1996, and three developed in 1997. The record contains five negative readings of the two 1974 films.(DX 39, 42, 46, 53). The record contains ten readings of the 1996 films, four of which are positive for pneumoconiosis. (DX 19, 20, 42, 46, 52, 57, 69). Of the remaining eight readings of the 1997 films, two are positive for pneumoconiosis.

Judge Donnelly gave the greatest weight to the readings of Drs. Forehand, Navani, Cole, Sargent, Mathur, and Gaziano (DX 20, 19, 52, 46, 93, 94) while discrediting other readings for failing to use the ILO-U/C interpretation of 0/0 for a negative reading.[3] Decision and Order at 28. The Board specifically held that Judge Donnelly erred in this treatment of the x-ray interpretations of Drs. Wheeler (DX 42), Scott (DX42), Fino (DX 46, 57), Castle (DX 69), Coburn (DX 70), Epling (DX 72) and Mullens (DX 72). BRB slip op. at 3, *citing* Decision and Order at 28. Thus, I will reweigh these readings against the positive x-ray readings of record.

[3]Of these six positive readings, four were interpreted by physicians who are both Board-certified and B-readers, while the remaining two by B-readers.

In my review of the chest x-rays of record, I find that the x-ray evidence does not establish pneumoconiosis. Pursuant to the Board's remand order, I specifically reconsidered the chest x-rays that Judge Donnelly previously discredited. The evidence of record includes six readings of the May 14, 1996 chest x-ray, three of which are positive for pneumoconiosis. Drs. Forehand, Navani, and Cole interpreted the film as positive for pneumoconiosis, with readings of 3/3, 2/3, and 3/2 respectively. (DX 20, 19, 52). Drs. Navani and Cole, both Board-certified and B-readers, observed parenchymal abnormalities consistent with pneumoconiosis as well as small irregular opacities; they did not , however, observe any pleural abnormalities consistent with pneumoconiosis. (DX 19, 52). Dr. Forehand, a B-reader, echoed these conclusions in his interpretation. (DX 20).

The record contains three negative readings of the May 14, 1996 film. Director's Exhibit 42 included rereadings by Drs. Wheeler and Scott, both Board-certified and B-readers. Both agreed that this film indicated neither parenchymal nor pleural abnormalities consistent with pneumoconiosis, but the film did show some abnormalities. (DX 42). Dr. Wheeler opined that the abnormalities were consistent with moderate nonspecific linear interstitial fibrosis and emphysema. (DX 42). Dr. Scott opined that the abnormalities were indicative of nonspecific linear fibrosis and, probably, usual interstitial pneumonitis. (DX 42). In addition, Dr. Fino, a B-reader, read the May 14, 1996 x-ray as negative for pneumoconiosis. (DX 57). Instead, Dr. Fino noted diffuse fibrotic changes in both lung fields, primarily concentrated in the middle and lower regions. (DX 57). An equal number of dually qualified physicians conflict over whether this x-ray is positive for pneumoconiosis. Thus, credentials do not enable me to give more weight to any of the aforementioned readings pursuant to *Cranor*. 22 BLR 1-1 (1999).

The record contains four readings of the October 22, 1996 film. Dr. Sargent, a B-reader, interpreted this chest x-ray as 3/3 with t/t opacities. In his deposition of December 17, 1996, Dr. Sargent stated, however, that the x-ray showed small irregular opacities that are not consistent with pneumoconiosis. Instead, Dr. Sargent opined that the film indicates interstitial pneumonitis or asbestos exposure, but not coal workers' pneumoconiosis. Judge Donnelly found, and the Board affirmed, that despite Dr. Sargent's comments about his interpretation, a 3/3 reading indicates pneumoconiosis.[4] *Cranor*, 22 BLR 1-1 (1999).

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[4]The Employer disputes the Board's decision regarding Dr. Sargent's interpretation of the October 22, 1996, x-ray. Citing § 902(b) of the Act, the Employer states that without proof of causation, a chest x-ray reading with an ILO of 3/3 does not alone satisfy the criteria of legal pneumoconiosis. The Employer further insists that while the legal definition of "coal workers' pneumoconiosis" is broader than the medical definition of "coal workers' pneumoconiosis," no such distinction exists between the legal definition of "coal workers' pneumoconiosis' and the medical definition of mere "pneumoconiosis." The Employer further argues that the legal definition of "coal workers' pneumoconiosis" relies on the ILO classification system that was designed to classify all types of pneumoconiosis–coal workers' pneumoconiosis or otherwise. According to the Employer, the medical definition of pneumoconiosis necessarily controls the satisfaction of the legal criteria of the Act and its implementing regulations. I do not find this argument convincing. The Fourth Circuit has

The remaining three readings of the October 22, 1996, film are negative for pneumoconiosis. (DX 46, 57, 69). In particular, Dr. Fino's report echoed his prior interpretation of the May 14, 1996, film. (DX 46). Drs. Castle and Scott observed neither parenchymal nor pleural abnormalities, but observed abnormalities consistent with usual interstitial pneumonitis. (DX 57, 69). Regarding the October 22, 1996, film, I accord greater weight to the interpretations of dually-qualified physicians, Drs. Castle and Scott, over that of the B-reader, Dr. Sargent. *Cranor,* 22 BLR. 1-1 (1999). Thus, I find that this x-ray is negative for pneumoconiosis.

Finally, the evidence of record contains eight readings of three 1997 films, only two of which are positive for pneumoconiosis. (DX 70, 94, 93, 108). Dr. Gazino, a B-reader, read the June 3, 1997, film as 3/3 with round opacities in six zones. (DX 94). Likewise, Dr. Mathur, who is Board-certified and a B-reader, interpreted the June 3, 1997, film as 3/4 with mixed round and irregular small opacities. (DX 93). Dr. Mathur commented that the film indicates co-existent pulmonary edema as well.

The remaining readings from the last month of the Miner's life, however, are overwhelmingly negative for pneumoconiosis. Drs. Coburn, Fino, and Scott read the June 3, 1997, x-ray as 0/0, and all concluded that the Miner suffered from interstitial fibrosis of unknown etiology. In addition, Dr. Wheeler read this film as 0/1 due to the presence of a few tiny nodules. (DX 108). Dr. Wheeler found usual interstitial pneumonitis due to moderate to marked interstitial fibrosis or infiltrates in the lower lungs and minimal interstitial fibrosis or infiltrates in periphery mid and upper lungs. (DX 108). Moreover, the record includes the June 5, 1997, report of Dr. Susan Epling of the Johnston Memorial Hospital Radiology Department, who concluded that the Miner suffered from severe chronic interstitial disease and mild cardiomegaly. Dr. Epling further commented that the diffuse interstitial disease did not significantly change in the Miner's lung fields since February 13, 1996. (DX 72). Overall, I accord greater weight to the readings of dually qualified physicians Drs. Mathur, Scott, and Wheeler. 22 BLR 1-1 (1999).

The last x-ray was completed on June 25, 1997, just two days prior to the Miner's unfortunate death. (DX 72). Dr. Mullens read the x-ray as indicating diffuse chronic interstitial disease, and superimposed alveolar process consistent with pneumonia in the right lower lobe. (DX 72).

Overall, only six of the eighteen readings of the 1996 and 1997 films were positive for pneumoconiosis. (DX 19, 52, 93). The remaining twelve negative readings observed that the Miner suffered from interstitial fibrosis, most likely idiopathic. Of the nine

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unequivocally held that the statutory criteria for establishing the condition necessary for the disposition of disability benefits "betrays no intent to incorporate a purely medical definition." *See Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 257 (4th Cir. 2000). The Fourth Circuit further noted that where the medical and legal standards diverge in the context of the Black Lung Act, the standards established by Congress must apply. *Id.*

interpretations submitted by dually qualified physicians, three are positive and six are negative for pneumoconiosis. Where the majority of the most qualified B-readers of record found no pneumoconiosis, the x-ray evidence fails to establish the existence of pneumoconiosis. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344 (1985). After weighing the credentials of the reviewing physicians and because the majority of chest x-rays are negative for pneumoconiosis, I find that the chest x-ray evidence fails to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1). 20 C.F.R. § 718.202(a)(1).

B. Biopsy and Autopsy Evidence

Pursuant to § 718.202 (a)(2), the Claimant may establish pneumoconiosis through the use of biopsy or autopsy evidence. 20 C.F.R. § 718.202 (a)(2). Here, the evidence of record contains both. The biopsy was performed by Dr. Denton in February 1996 at the direction of Dr. Robinette. (DX). The autopsy was completed more than a year later in June 1997, by Dr. Buddington. (DX 72).

1. Biopsy Evidence

Upon my review of the biopsy reports of the reviewing physicians, I find that the biopsy evidence does not establish pneumoconiosis. Drs. Caffrey, Tomashefski, Naeye, and Kleinerman, all of whom are Board-certified pathologists, reviewed the biopsy evidence and all diagnosed either usual interstitial pneumonitis or usual interstitial pneumonia with advanced interstitial fibrosis. (DX 41, 46, 63, 64, 66, 67). While some reviewing physicians found anthracotic pigmentation in the biopsy evidence, none diagnosed pneumoconiosis upon examination of the pathological evidence due to the absence of coal macules, micronodules, silicotic nodules or a significant deposition of birefringent crystals. (DX 41, 46, 63, 64, 66, 67).

Section 718.202(a)(2) states that where a biopsy indicates anthracotic pigment without more, the biopsy is negative for pneumoconiosis. 20 C.F.R. § 718.202(a)(2). The regulations specify, however, that a negative biopsy is not conclusive evidence that the Miner does not have pneumoconiosis. 20 C.F.R. § 718.106(c). Moreover, while § 718.202(a)(2) states that a biopsy or autopsy showing anthracotic pigmentation is insufficient, by itself, to establish the existence of pneumoconiosis, the Fourth Circuit Court has held that no piece of medical evidence shall be considered in a vacuum. *See Compton*, 211 F.3d at 208-209, *citing* 20 C.F.R. § 718.202(a). Instead, all evidence at §§ 718.202(a)(1)-(4) must be considered together to determine whether the Claimant has established the existence of pneumoconiosis. *Id.* Thus, the negative biopsy must be weighed further against the chest x-rays, autopsy and medical opinions that support a finding of pneumoconiosis. *Id.*

2. Autopsy Evidence

Upon my review, I find that the autopsy evidence does not establish pneumoconiosis. Dr. Buddington, a Board-certified pathologist, performed the autopsy on June 27, 1997. (DX 72). He found that the Miner's lungs were of a condition consistent

with “severe” coal workers’ pneumoconiosis. (DX 72). In his preliminary autopsy report of June 27, 1997, Dr. Buddington diagnosed bilateral pneumonia, severe pulmonary fibrosis, emphysema and anthracosis, and moderate coronary artery atherosclerosis. (DX 72). The prosector’s gross observations of the Miner’s lungs included: fibro-adipose pleural adhesions, bilateral; increase in the lungs’ weights; cobblestone looking pleural surfaces; sub-pleural emphysematous bullae, bilateral; pulmonary perenchyma of all lobes is markedly consolidated, tan-red with prominent para-septal anthracosis; pan-lobular emphysema; diffuse sub-pleural fibrosis; markedly anthracotic, enlarged hilar and mediastinal lymph nodes. (DX 72). His gross observations of the heart included: weight of 340 grams; moderate coronary arteriosclerosis not exceeding 50%; marked hypertrophy of right ventricle and slight of left ventricle. In his final anatomic diagnoses, Dr. Buddington noted that the Miner’s lungs were “consistent with coal worker’s pneumoconiosis, severe.” (DX 72). These diagnoses were based on the gross examination only. (DX 72).

Thereafter, Dr. Buddington issued a final report after the completion of a microscopic examination. (DX 72). Based on microscopic examination of the lungs, Dr. Buddington concluded that the lungs were markedly abnormal, and had a dense fibrosis with large amounts of black anthracotic pigment. (DX 72). Dr. Buddington found that hilar lymph nodes indicated anthracosis as well. (DX 72). The legal definition of pneumoconiosis includes, but is not limited to, anthracosis. 20 C.F.R. § 718.201(a). Therefore, Dr. Buddington’s autopsy report, absent credible pathology reports to the contrary, may establish pneumoconiosis.

An ALJ cannot accord complete deference to the autopsy prosector without first determining the credibility and weight of the reviewing pathologists’ contrary opinions. *Urgolites v. Bethenergy Mines, Inc.*, 17 BLR 1-20 (1992). Absent evidence that access to the body enhances the accuracy of diagnoses based on autopsy evidence, the Fourth Circuit has held that it is error for the ALJ to credit the prosector's opinion over those opinions of reviewing pathologists solely on the basis that the prosector examined the miner's whole body at the time of death. *See Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186 (4th Cir. 2000). Accordingly, the Employer argues that Dr. Buddington’s conclusions do not deserve greater weight under the “preferred prosector” rule because Dr. Buddington’s report does not indicate how the gross examination was the basis for his conclusions. (Emp. Brief, 1/8/01, at 5, *citing Bill Branch Coal Corp. v.* Sparks, 213 F.3d 186, 192 (4th Cir. 2000); *Sewell Coal Co. v. Bragg*, No. 96-2512, 1997 U.S. App. LEXIS 17397 (4th Cir. July 11, 1997)(unpub.). However, as the Fourth Circuit noted in *Piney Mountain Coal*, the gross appearance of the Miner’s lungs at autopsy was not and cannot be either contradicted nor corroborated by any reviewing physician. *See Piney Mountain Coal*, 176 F.3d at 762.

Nonetheless, Drs. Tomashefski, Caffrey, Kleinerman and Crouch reviewed the autopsy evidence and concluded that interstitial fibrosis with consequent respiratory failure caused the Miner’s death. (DX 102, 107). Dr. Tomashefski maintained that the autopsy evidence established idiopathic pulmonary fibrosis, but not pneumoconiosis. (DX 102). Due to just mild evidence of coal dust exposure, Dr. Caffrey likewise maintained that the autopsy evidence was not consistent with coal workers’ pneumoconiosis, but indicated

that the Miner suffered from usual interstitial pneumonia that rapidly progressed to diffuse pulmonary fibrosis. (DX 102). Dr. Caffrey also opined that most cases of interstitial pneumonia are idiopathic. (DX 102). Dr. Crouch noted a "mild" deposition of black to dark brown coal dust particles and a small amount of birefringent particles consistent with silicates, but no coal dust macules or nodules were found. (DX 107). Overall, none of these reviewing physicians agreed with Dr. Buddington's microscopic observations of large amounts of black anthracotic pigment.

Despite finding the presence of black granular pigment in the lung tissue, Dr. Kleinerman stated that the autopsy evidence establishes that the Miner did not have simple or complicated coal workers' pneumoconiosis. Dr. Kleinerman recounted the criteria for finding coal workers' pneumoconiosis as (1) the macule, a nodular locus of cellular fibrosis and black pigment (2) in the site, adjacent to a respiratory bronchiole, and (3) a small area of airspace enlargement adjacent to the macule. (DX 102). Dr. Kleinerman concluded that none of the aforementioned criteria are satisfied by the autopsy evidence. (DX 102). The regulations are devoid of the criteria by which Dr. Kleinerman evaluated the autopsy evidence.

Dr. Perper, a Board-certified pathologist, also studied the autopsy and opined that the autopsy indicates diffuse interstitial fibrosis in the Miner's lower lung. (DX 92). He further opined that this condition is a "variant" of coal workers' pneumoconiosis. (DX 92). Dr. Perper found that the "numerous" silica and bifringent crystals he observed substantiates his theory that the fibrosis is not idiopathic, but caused by the Miner's coal dust exposure. (DX 92). Dr. Perper based this connection on various articles, all of which were reviewed and discredited by Dr. Kleinerman. (DX 106). Moreover, Drs. Tomashefski, Caffrey, and Couch all noted that very few silica were observed. (DX 102, 107). Therefore, I find that Dr. Perper's opinion regarding the autopsy is limited to his finding of interstitial fibrosis.

Overall, I find that the autopsy evidence does not establish pneumoconiosis. While there is no evidence to refute the prosector's gross examination observations, there is a great disparity between the prosector's microscopic observations and those of the five reviewing pathologists. Because the Fourth Circuit has held that it is necessary to weigh the credibility of the opinions contrary to that of the prosector, I must consider the qualifications of each pathologist consulted. *See generally Sparks*, 213 F.3d 186. While the prosector and all reviewing physicians are Board-certified pathologists, Dr. Kleinerman's qualifications are superior to all of the pathologists who reviewed the autopsy evidence as well as the prosector. (DX 41, 44, 74, 91, 102, 107). *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, n. 2 (4th Cir. 1997). In 1979, Dr. Kleinerman served on the Pneumoconiosis Committee of the College of American Pathologists that developed for the National Institute for Occupational Safety and Health the pathology standards by which to diagnose coal workers' pneumoconiosis. (DX 64, 67, 102). Dr. Kleinerman has published numerous articles regarding the pathology of industrial pulmonary diseases. (DX 64, 67, 102). He is a tenured professor of Pathology at Case Western Reserve University School of Medicine. (DX 64, 67, 102). He has served as a member of the American College of Radiology Task Force on Pneumoconiosis since

1984. (DX 64, 67, 102). Of the pathologists that reviewed the autopsy evidence, only Dr. Kleinerman has published an extensively on the subject of diagnosing pneumoconiosis pathologically. (DX 41, 44, 74, 91, 102, 107). In light of his superior qualifications, Dr. Kleinerman's opinion that the autopsy evidence reveals diffuse nonspecific interstitial pneumonitis and interstitial fibrosis unrelated to coal dust inhalation merits significant probative weight. Accordingly, I find that the preponderance of the autopsy evidence establishes that the Miner suffered from interstitial fibrosis, but not coal workers' pneumoconiosis.

C. The Presumptions

Under §718.202(a)(3) it shall be presumed that a miner is suffering or suffered from pneumoconiosis if the presumptions provided in §§ 718.304, 718.305, or 718.306 apply. Initially I note that Claimant cannot qualify for the § 718.305 presumption because he did not file before January 1, 1982. Claimant is also ineligible for the § 718.306 presumption because the Miner did not die on or before March 1, 1978.

Section 718.304 provides an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, that a miner's death was due to pneumoconiosis, or that a miner was totally disabled due to pneumoconiosis at the time of his death where such miner is suffering or suffered from complicated pneumoconiosis. Complicated pneumoconiosis will be considered established where the miner is suffering or suffered from a chronic dust disease of the lung which when (1) diagnosed by x-ray reveals one or more large opacities (greater than one centimeter in diameter) classified in Category A, B, or C or (2) diagnosed by biopsy or autopsy yields massive lesions in the lung; or (3) diagnosed by other means would be a condition which could reasonably be expected to yield the results describe in (1) or (2). Based on the evidence of record, I find that Claimant is not entitled to the § 718.304 presumption.

D. Medical Opinions

Lastly, under § 718.202(a)(4), a finding of pneumoconiosis may be based on the opinion of a physician, exercising sound medical judgment, who concludes that the Miner suffers or suffered from pneumoconiosis. Such conclusion must be based on objective medical evidence such as blood gas studies, electrocardiograms (EKG), pulmonary function studies (PFS), physical performance tests, physical examinations, and medical and work histories, and must be supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a)(4). The legal definition of pneumoconiosis includes "any obstructive or restrictive lung disease" arising out of coal mine employment. *See Gulf & Western Industries v. Ling*, 176 F.3d 226 (4th Cir. 1999); *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337 (4th Cir. 1996). Of record to consider are the opinions of Drs. Robinette, Forehand, Perper, Tomashefski, Sargent, Caffrey, Castle, Naeye, Fino, and Kleinerman. Only Drs. Robinette, Forehand, and Perper concluded that the Miner suffered from coal workers pneumoconiosis. The remaining physicians opined that the Miner indeed suffered from interstitial fibrosis;

however, they found that the disease was idiopathic and, thus, did not arise out of his coal mine employment.

To merit probative weight, a medical opinion must be well-documented and well-reasoned. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Id.* A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Id.* Therefore, to determine whether a medical opinion is both well documented and well reasoned, an "ALJ must examine the reasoning employed in a medical opinion in light of the objective material supporting that opinion, and also must take into account any contrary test results or diagnoses." *Compton*, 211 F.3d at 211, *quoting Director, OWCP v. Rowe* , 710 F.2d 251, 255 (6th Cir. 1983).

Dr. Robinette, who is Board-certified in internal and pulmonary medicine, first treated the Miner upon the Miner's hospitalization in February 1996, and continued to treat the Miner for his pulmonary disease until the Miner's death on June 27, 1997. (DX 41, 68). In the eighteen months prior to the Miner's death, Dr. Robinette saw the Miner on an almost monthly basis, and attended to him during four hospitalizations. (DX 47, 68, 53). Under Dr. Robinette's care, the Miner submitted to a myriad of testing including, but not limited to, chest x-ray, pulmonary function study (PFS), arterial blood gas study (ABGS), a biopsy, a CT scan, and regular physical examinations. Dr. Robinette's role as the Miner's treating physician "entitles his opinion to great, though not necessarily dispositive, weight'" so long as his opinion is both well documented and well reasoned. *See Piney Mountain Coal*, 176 F.3d at 768, *quoting*, *Grigg v. Director, OWCP*, 28 F.3d 416, 420 (4th Cir. 1994).

In his report of February 13, 1996, Dr. Robinette summarized both the Miner's January 6, 1996, emergency room evaluation at the Johnston Memorial Hospital, as well as his own initial testing and medical evaluation of the Miner prior to his admission to the Johnston Memorial Hospital for an elective thoracoscopy biopsy of his lung. (DX 41). The January emergency room evaluation included a chest x-ray, ABGS, and a physical examination. (DX 41). The x-rays demonstrated "changes consistent with a mixed interstitial and alveolar infiltrate." (DX 41). The ABGS was noted as "poor" with a PO2 of 54. (DX 41). Furthermore, the Miner was found to be "grossly cyanotic." (DX 41).

In examining the Miner, Dr. Robinette noted the Miner's subjective complaints of exertional breathlessness and dyspnea, but no significant sputum production. (DX 41). In addition, Dr. Robinette noted the Miner's 44 years of coal mine employment as well as his 40 year cigarette smoking history. (DX 41). A chest examination of the Miner revealed no rales, rhonchi or wheezes, while an examination of the Miner's extremities showed evidence of cyanosis and clubbing. (DX 41). It is notable that Dr. Robinette opined that the chest x-ray conducted demonstrated "evidence of a peripheral alveolar filling process consistent with idiopathic pulmonary fibrosis or eosinophilic pneumonia." (DX 41). Dr. Robinette also stated that a CT scan of the thorax was performed and revealed evidence of diffuse interstitial lung disease most marked in the mid and lower lung zones with a "ground-glass" appearance not associated with adenopathy in the mediastinum. (DX 41).

A PFS conducted on February 9, 1996, resulted in FEV-1 of 1.07 (predicted normal value is 1.64), and FVC of 1.82 (predicted normal value is 2.10) and an FEV-1/FVC of 59%. (DX 41). Accordingly, Dr. Robinette stated that the PFS confirmed that the Miner suffered a "severe restrictive and obstructive lung disease with marked impairment of the diffusion capacity." (DX 41).

Based on the aforementioned evidence, Dr. Robinette stated that the Miner most likely suffered from an acute interstitial fibrotic pulmonary disorder, and accordingly recommended that the Miner have a lung biopsy. (DX 41). Finally, the admission diagnoses were listed as (1) probable idiopathic pulmonary fibrosis; (2) history of coal dust exposure with probable black lung disease; and (3) severe hypoxemia secondary to #1 and #2. (DX 41). The pre-operative diagnosis was "Diffuse pulmonary fibrosis versus a pneumonitis versus carcinomatosis." (DX 41).

The open lung biopsy was completed by Dr. Denton on February 13, 1996. (DX 10, 41). Upon sectioning, the lung pernchyma appeared "meaty tan red and subcrepitant with dilated bronchiales filled a cloudy tenacious mucous." (DX 10, 41). The pleural surface was noted to be smooth, tan to purple in color. (DX 10, 41). Dr. Denton's gross observations did not include any mention of black pigment, pneumoconiosis, or any of the conditions that would constitute legal pneumoconiosis pursuant to § 718.201. (DX 10, 41). 20 C.F.R. § 718.201. Dr. Hudgens of the Intermountain Pathology Associates read the biopsy and specifically found diffuse interstitial pneumonitis consistent with interstitial fibrosis. (DX 10, 41). Absent from Dr. Hudgens's evaluation is any mention of coal macules, micronodules, silicotic nodules or a significant deposition of birefringent crystals. (DX 10, 41).

Upon the Miner's discharge from the hospital following the open lung biopsy, Dr. Robinette completed another report. (DX 10). In this report, Dr. Robinette stated that the biopsy revealed a diffuse process involving both the upper and lower lungs, and "it appeared to be a severe fibrotic process." (DX 10). Dr. Robinette further stated that the biopsy contained "evidence of anthracosis present grossly." (DX 10). Dr. Robinette listed the clinical diagnosis as "diffuse interstitial pneumonitis superimposed on presumptive occupational pneumoconiosis." (DX 10). In concluding his discharge report, Dr. Robinette diagnosed: (1) Pulmonary fibrosis with hypoxemia with apparent clinical interstitial pneumonitis consistent with usual interstitial pneumonitis and associated pulmonary fibrosis; (2) Coal workers' pneumoconiosis with chronic obstructive pulmonary disease; (3) Hypoxemia, secondary to #1 and #2. (DX 10). After this assessment in February 1996, Dr. Robinette maintained in all of the Miner's records that the Miner suffered from "interstitial fibrosis with coal workers' pneumoconiosis." (DX 47).

The Employer alleges that Dr. Robinette diagnosed coal workers' pneumoconiosis without providing a proper rationale. (Emp. Brief, 1/8/01, at 11). In my review of the record, it is evident that Dr. Robinette relied on a myriad of objective medical evidence in diagnosing the Miner's pulmonary condition. Dr. Robinette's notes and reports generated throughout his treatment of the Miner clearly and consistently explain his diagnosis of a

restrictive lung condition caused by diffuse interstitial fibrosis. Absent from Dr. Robinette's medical opinion, however, is a clear and consistent basis for diagnosing coal workers' pneumoconiosis as an additional cause of this restrictive lung impairment. Therefore, I find that Dr. Robinette's medical opinion is well-documented, though not well-reasoned. *See Compton*, 211 F.3d at 211, *quoting Director, OWCP v. Rowe* , 710 F.2d 251, 255 (6th Cir. 1983).

In his pre-biopsy report of February 13, 1996, Dr. Robinette interpreted the medical evidence generated at that time as showing idiopathic pulmonary fibrosis, and merely noted the possibility of black lung disease due to the Miner's occupational history. (DX 41; Emp. Brief, 1/8/01, at 11). Although the biopsy was interpreted as negative for pneumoconiosis, Dr. Robinette stated that the biopsy evidence revealed interstitial pneumonitis "superimposed on presumptive occupational pneumoconiosis." (DX 41). As discussed herein, the biopsy evidence did not establish clinical pneumoconiosis. Apparently, Dr. Robinette continued to"presume" that the Miner had black lung disease despite the medical evidence in his possession at that point. Nonetheless, Dr. Robinette stated in subsequent reports that the biopsy evidence of interstitial fibrosis was "superimposed on apparent black lung disease" without explaining why his medical opinion changed from "presumptive" to "apparent" coal workers' pneumoconiosis. (DX 41, 47, 68). It is also noteworthy that Dr. Robinette's description of the Miner's condition remained inconsistent in notes made throughout his treatment of the Miner. (DX 47, 68). In my review of Dr. Robinette's reports, I found instances in which he labels the Miner's condition as "presumptive coal workers' pneumoconiosis" after he had listed it as "apparent" in the previous report. (DX 47, 68). Overall, Dr. Robinette cited only the February 9, 1996, biopsy to support his diagnosis of coal workers' pneumoconiosis. (DX 10, 41, 70). Yet, in so doing, Dr. Robinette mischaracterized the biopsy evidence as having shown "generalized blackening of the lungs grossly." (DX 10, 41, 70). Accordingly, I find that Dr. Robinette simply failed to explain what medical evidence enabled his opinion to change from "presumptive" pneumoconiosis to "apparent" pneumoconiosis, such that Dr. Robinette's various medical reports in sum provide no more than conclusory statements that the Miner suffered from coal workers' pneumoconiosis. Dr. Robinette's medical opinion is riddled with inconsistencies, and is therefore equivocal and vague. Thus, the medical opinion of Dr. Robinette is entitled to little weight.

Moreover, the Employer correctly argues that because Dr. Robinette used the term "idiopathic" in describing the interstitial fibrosis, Dr. Robinette necessarily opined that the interstitial fibrosis did not arise out of the Miner's coal mine employment. (Emp. Brief, 1/8/01, at 11). Therefore, Dr. Robinette's medical opinion does not support a finding that the Miner's interstitial fibrosis arose out of the Miner's coal mine employment.

On behalf of the DOL, on May 14, 1996, Dr. Forehand conducted a physical examination, social and occupational histories, x-ray, pulmonary function study, arterial blood gas study, and EKG. (DX 11). The Miner's subjective complaints to Dr. Forehand included dyspnea and ankle edema, but not chest pain, wheezing or productive cough. (DX 11). He also noted that the Miner's breath sounded diminished and crackles at base. (DX 11). Upon completing a chest x-ray of the Miner, Dr. Forehand, a B-reader,

interpreted the film as 3/3. (DX 20). Dr. Forehand read the EKG results as indicating "evolving cor pulmonale." (DX 11). The ABGS at rest resulted in a pCO2 of 31 (predicted normal range is 35-45); pO2 of 34 (predicted normal range is 80-90); and pH of 7.47 (predicted normal range is 7.35-7.45). (DX 12). From the ABGS, Dr. Forehand opined that the Miner was hypoxic at rest. (DX 11). This ABGS was subsequently invalidated by Dr. Ranavaya due to technical errors. (DX 13, 14). Due to this invalidation, the DOL had Dr. Forehand conduct a second ABGS on June 28, 1996. (DX 14, 16). This time, the ABGS resulted in a pCO2 of 35 (predicted normal range is 35-45); pO2 of 54 (predicted normal range is 80-90); and pH of 7.48 (predicted normal range is 7.35-7.45). On behalf of the DOL, Dr. Michos, who is Board-certified in internal medicine and pulmonary disease, reviewed and validated this ABGS. (DX 17, 18).

The PFS of May 14, 1996, resulted in FEV-1 of 1.44 pre-bronchodilator and 1.50 post-bronchodilator (predicted normal value is 1.64); MVV of 78 pre-bronchodilator and 91 post-bronchodilator (predicted normal value is 65); and FVC of 1.76 pre-bronchodilator and 1.82 post-bronchodilator (predicted normal value is 2.10). (DX 9). Dr. Forehand noted that the Miner was cooperative and exerted good effort for the purposes of this PFS. (DX 9). From this PFS, Dr. Forehand opined that the Miner suffered from a restrictive lung disease. (DX 11). Overall, Dr. Forehand opined that the Miner suffered from diffuse pulmonary fibrosis and cor pulmonale due to coal dust exposure. (DX 11).

Additionally, Dr. Forehand reviewed the biopsy evidence as well as the reports of Drs. Caffrey and Tomashefski. (DX 48). Dr. Forehand opined that the absence of macules and nodules in the lower lobe does not contradict a finding of coal workers' pneumoconiosis, and he referred to a 1993 article from a peer-review journal to support this position. According to Dr. Forehand, this article establishes that while most cases of coal workers' pneumoconiosis typically have a pattern of a reticulonodular disease, others develop a pattern consistent with diffuse interstitial fibrosis. (DX 48). Therefore, Dr. Forehand did not change his original diagnosis in light of the biopsy evidence. (DX 48).

Dr. Perper, who is Board-certified in anatomical, surgical and forensic pathology, reviewed the medical evidence of record, including the pathological evidence, and opined in his September 12, 1997, report that the Miner suffered from diffuse interstitial pulmonary fibrosis. (DX 91, 92). Although the autopsy did not show "typical evidence of the typical simple or complicated coal workers' pneumoconiosis, Dr. Perper stated that the Miner's diffuse interstitial fibrosis is a "variant" of coal workers' pneumoconiosis. (DX 92). In support of this opinion, Dr. Perper cited the Miner's occupational history, and stated that he observed in the autopsy tiny birefringent crystals consistent with silica scattered throughout the areas of fibrosis. (DX 92). Dr. Perper referenced the article upon which Dr. Forehand also relied in making a connection between the Miner's coal mine employment and the diffuse interstitial pulmonary fibrosis. (DX 92). In reviewing the record, I note that Dr. Perper's interpretation of the pathology evidence is contrary to the findings of Drs. Kleinerman, Tomashefski, Caffrey, and Naeye. (DX 66. 67, 69, 71). Based on the absence of silicotic nodules, Dr. Tomashefski refutes Dr. Perper's conclusion that the pathology evidence contained birefringent crystals sufficient to substantiate a finding that the interstitial fibrosis is a variant of coal workers' pneumoconiosis. (DX 106).

Drs. Sargent, Kleinerman, Fino, Castle, and Tomashefski each invalidated the articles cited by Drs. Forehand and Perper to support their opinions that the Miner's diffuse interstitial fibrosis is related to coal dust exposure. (DX 66, 67, 69, 71, 106, 108). Specifically, Dr. Tomashefski found that only 1% of the subjects in a cited study had coal workers' pneumoconiosis, and the article does not specify whether any of that 1% also suffered from diffuse interstitial fibrosis. (DX 66). Likewise, Dr. Sargent found that the articles targeted silicosis related to the inhalation of a variety of dusts, and not just silicosis arising out of coal dust inhalation. (DX 66). Moreover, Dr. Kleinerman disputes Drs. Forehand's failure to explain how coal dust exposure and diffuse interstitial fibrosis are related when no coal and/or silica were found in areas containing diffuse interstitial fibrosis. (DX 67). Finally, Dr. Fino reviewed a 1993 article upon which both Drs. Forehand and Perper relied and quoted the study's exact conclusion:"there was no correlation between the occurrence of diffuse interstitial fibrosis and the type of the underlying disease (silicosis or mixed dust pneumoconiosis)." (DX 69). Thus, Drs. Sargent, Kleinerman, Fino, Castle, and Tomashefski concluded that the articles cited failed to establish that diffuse interstitial fibrosis, in the absence of coal dust or coal dust-lesions, is due to coal dust exposure. (DX 66, 67, 69, 71, 106, 108).

I find that Drs. Forehand and Perper's reliance on the cited articles to be unreasonable. As the Fourth Circuit has held, it is reasonable to discredit medical opinions regarding the link between interstitial pulmonary fibrosis and coal dust exposure based on an article where the substance of the article is countered by significant expert criticisms. *See Consolidated Coal Company v. Latusek*, 187 F.3d 628, 1999WL 592051, 3-4 (4th Cir. 1999) (unpub.). Similar to the discredited articles in *Latusek*, the articles here were criticized by several well-qualified physicians as lacking in appropriate sampling methods as well as in general acceptance within the relevant scientific community. *Id.* Therefore, I find that Drs. Forehand and Perper's opinions that the Miner's diffuse pulmonary fibrosis is related to coal dust exposure merit little probative value in establishing pneumoconiosis under § 718.202(a)(4).

Dr. Sargent, who is Board-certified in internal medicine and pulmonary diseases, examined the Miner on October 22, 1996. (DX 44). Dr. Sargent conducted a PFS, ABGS, EKG, and noted the Miner's medical and occupational history. (DX 44). Despite his interpretation of a chest x-ray as 3/3, Dr. Sargent stated that the x-ray does not indicate coal workers' pneumoconiosis because the opacities observed are irregular instead of rounded. (DX 44). Dr. Sargent also reviewed the biopsy evidence in forming his medical opinion, and noted the absence of coal macules that he terms "the hallmark of coal workers' pneumoconiosis." (DX 44). Additionally, Dr. Sargent opined that the PFS indicates that the Miner suffered from a severe restrictive ventilatory impairment, but such condition was unrelated to coal mine employment. (DX 44). Dr. Sargent stated that coal workers' pneumoconiosis necessarily causes a "mixed obstructive and restrictive pattern," and because the Miner's ventilatory impairment is "purely restrictive," this Miner does not

suffer from coal workers' pneumoconiosis. (DX 44). Overall, Dr. Sargent concluded that the Miner suffered from usual interstitial pneumonitis unrelated to coal dust exposure.

While Dr. Sargent's medical opinion is well-documented and well-reasoned, I must reiterate that the Fourth Circuit defines legal pneumoconiosis to include "any obstructive or restrictive lung disease" arising out of coal mine employment. *See Gulf & Western Industries v. Ling*, 176 F.3d 226 (4th Cir. 1999); *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337 (4th Cir. 1996). Thus, if Dr. Sargent or any of the consulting physicians found that the Miner suffered from a purely restrictive lung disease arising out of his coal mine employment, then that opinion would serve to establish pneumoconiosis. 20 C.F.R. § 718.201. In the instant matter, however, Dr. Sargent opined that the Miner suffered from a restrictive ventilatory impairment caused by idiopathic interstitial fibrosis that is unrelated to coal dust exposure. Therefore, I find that Dr. Sargent's medical opinion merits probative weight under § 718.202(a)(4).

Dr. Castle reviewed all of the evidence of record, and submitted his medical opinion in the report of July 25, 1997. (DX 71). Dr. Castle, who is Board-certified in pulmonary medicine, noted Dr. Robinette's lone diagnosis of coal workers' pneumoconiosis in the face of the biopsy evidence that was read as negative for pneumoconiosis by all reviewing pathologists. (DX 71). Overall, Dr. Castle opined that his review of all medical data established that the Miner had "all clinical features of usual interstitial pneumonitits" with "pathological confirmation of this diagnosis" as well as "unequivocal evidence that there was no change of coal workers' pneumoconiosis present." (DX 71). Dr. Castle concluded that the Miner's interstitial fibrosis caused his pulmonary disability, and that this condition did not arise out of coal mine employment. (DX 71).

The consulting pathologists of record also submitted medical opinions upon reviewing the objective medical evidence gathered by the examining physicians. Dr. Naeye, who is Board-certified in anatomical and clinical pathology, reviewed the PFS, ABGS, biopsy, and consultation reports of Drs. Caffrey, Forehand, Fino, Sargent, Scott, Wheeler, Robinette and Cunningham. (DX 64). In his review of the biopsy evidence, Dr. Naeye found that the fibrous tissue had no relationship to the small amount of black pigment observed. He noted the absence of birefringement crystals as well. Finding that the "dominating abnormality in these lung samples is interstitial fibrosis," Dr. Naeye stated that the Miner suffered from severe centrilobular emphysema not attributable to coal mine dust exposure. (DX 64). Overall, Dr. Naeye opined that the Miner did not suffer from coal workers' pneumoconiosis. (DX 64).

I find that Dr. Naeye's medical opinion is both well-documented and well-reasoned. Like Dr. Sargent, Dr. Naeye stated that the PFS of record indicated an "entirely restrictive" disease whereas "airway obstruction is a characteristic component of CWP." (DX 64). Accordingly, Dr. Naeye stated that the PFS results are not compatible with coal workers' pneumoconiosis. (DX 64). However, as stated with regard to the opinion of Dr. Sargent, the Fourth Circuit has determined that the legal definition of pneumoconiosis is satisfied by a

finding of an obstructive or restrictive lung disease so long as it is caused by coal dust inhalation. *See Gulf & Western Industries v. Ling*, 176 F.3d 226 (4th Cir. 1999); *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Stiltner v. Island Creek Coal Co.*, 86 F.3d 337 (4th Cir. 1996). In this case, Dr. Naeye found that the Miner's restrictive pulmonary disease was caused by interstitial fibrosis unrelated to coal dust inhalation. Therefore, Dr. Naeye's medical opinion merits probative value under § 718.202(a)(4).

Dr. Tomashefski, who is Board-certified in anatomical and clinical pathology, reviewed the following medical records: an admission history and physical examination; the operative note, surgical pathology report, and the post-operative discharge summary of the February 13, 1996, open lung biopsy; and five slides from the biopsy. (DX 44). Due to the absence of coal macules, micronodules, silicotic nodules, and without a significant deposition of birefringent crystals in the biopsy evidence, Dr. Tomashefski opined that the Miner did not suffer from coal worker's pneumoconiosis. (DX 44). Instead, Dr. Tomashefski diagnosed usual interstitial pneumonia with advanced interstitial fibrosis that is idiopathic, and thus did not arise out of the Miner's coal mine employment. (DX 44).

Dr. Kleinerman, who is Board-certified in anatomical and clinical pathology, reviewed the medical evidence of record and concluded that the Miner does not suffer from coal workers' pneumoconiosis. (DX 67). Upon my review of Dr. Kleinerman's medical opinion, it is clear that he used the biopsy evidence as the sole basis of his conclusions. Specifically, Dr. Kleinerman noted the absence of lesions typical of simple coal workers' pneumoconiosis, simple nodular silicosis, and complicated pneumoconiosis. Therefore, Dr. Kleinerman opined that the Miner suffered from diffuse nonspecific interstitial pneumonitis and interstitial fibrosis that are not caused by coal dust inhalation, but are idiopathic. (DX 67).

Finally, Dr. Fino, who is Board-certified in internal medicine and pulmonary diseases, reviewed the medical evidence of record and submitted three reports. (DX 46). In light of his review of the CT scan of February 9, 1996, Dr. Fino stated that the test revealed no pleural or no parenchymal abnormalities consistent with an occupational pneumoconiosis. (DX 46). Instead, Dr. Fino noted changes consistent with bullous emphysema. (DX 46). Upon his review of the October 22, 1996, x-ray film, Dr. Fino noted diffuse fibrotic changes in both lung fields that he believed to be unrelated to coal dust inhalation. (DX 46). At that time, Dr. Fino opined that the Miner did not suffer from pneumoconiosis, but from diffuse interstitial fibrosis unrelated to coal dust exposure.

Dr. Fino submitted a final report on July 18, 1997, in which he reviewed all medical evidence generated until that point, except the autopsy evidence. (DX 69). Dr. Fino reviewed and invalidated the February 9, 1996, PFS. (DX 69). Dr. Fino stated that the spirometry was invalid because of a premature termination to exhalation, a lack of reproducibility in the expiratory tracings, and a lack of an abrupt onset to exhalation. (DX 69). Therefore, Dr. Fino opined that the values recorded do not represent the Miner's maximum lung function. (DX 69). Dr. Fino did validate the May 14, 1996, PFS, and opined that this study indicated that the Miner suffered from a restrictive ventilatory defect. (DX 69). Dr. Fino also stated that the various ABGS of record showed hypoxia. (DX 69).

Moreover, Dr. Fino opined that lung biopsy evidence is necessary to absolutely determine the cause of the Miner's restrictive lung condition. (DX 69). In this case, Dr. Fino found that the biopsy evidence showed no indications of coal workers' pneumoconiosis, but established diffuse interstitial pulmonary fibrosis. (DX 69). Dr. Fino concluded that the Miner's severe hypoxia and restrictive lung disease are all related to the diffuse interstitial pulmonary fibrosis, and are not related to the inhalation of coal mine dust. (DX 69). Because Dr. Fino's medical opinion is well-documented and well-reasoned, I find that it merits probative weight.

Conclusion

After weighing all the evidence relevant to the existence of pneumoconiosis, I find that the Claimant failed to establish the existence of pneumoconiosis. The x-ray evidence, the biopsy evidence, and the medical opinions fail to establish pneumoconiosis according to both the clinical and legal definitions. While the autopsy report of Dr. Buddington supports a finding of pneumoconiosis, contrary evidence outweighs this report. The Board has affirmed a finding that the claimant failed to establish the existence of pneumoconiosis even where the x-ray evidence was positive because the weight of the other medical evidence indicated that the claimant's impairment was due to interstitial fibrosis of unknown etiology. *See Mabe v. Bishop Coal Co.*, 9 BLR 1-67, 1-68 (1986). Here, the weight of the medical evidence establishes that the Claimant's impairment was due to interstitial fibrosis, idiopathic in nature. The etiology of the Miner's disability is uncertain, and "uncertainty is not proof, and claimant's must prove entitlement." *Piney Mountain Coal*, 176 F.3d at 763. Because the Claimant failed to produce sufficient evidence to prove that the Miner's interstitial fibrosis was due to his coal mine employment, I cannot reasonably find that the Claimant met her burden of proof. Therefore, since Claimant has not established the first element of her case, that is, the existence of pneumoconiosis, she is not entitled to benefits. The Miner's claim fails for the same reason. Because this disease is not established, it is not necessary to discuss total disability and cause of death.

ORDER

The claim of Sylvia J. Tarr, Widow of Edward G. Tarr, and the Miner's claim for benefits under the Act are DENIED.

A

Ainsworth H. Brown
Administrative Law Judge

Attorney Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to Claimant for services rendered to him in pursuit of this claim.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F. R. §725.481, any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, DC 20210.